Utah VFC
Utah Vaccines for Children

VFC PIN#_____
CY 2007

Provider Profile and Enrollment

Physician: _____
First MI Last Title

Clinic Name: _____

Type of Facility:
- ☐ A. Public Health Department
- ☐ B. Private Practice (Individual or Group)
- ☐ C. Federally Qualified Health Center (FQHC)
- ☐ D. Certified Rural Health Clinic (RHC)*
- ☐ E. Other Facility _____

*__Note:__ If claiming FQHC or RHC status, you must be Federally certified.

Contact Person: _____
First Last Title

Vaccine Delivery Address: _____
Street Only (No P.O. Boxes)

_____ _____ _____
City State Zip

Mailing Address: _____
Street or PO Box

_____ _____ _____
City State Zip

Email Address: _____

Telephone: ( )_____ Extension_____ **Fax:** ( )_____

Days and Times Vaccine May be Delivered: Mon. _____AM to_____PM Tues. _____AM to_____PM

Wed. _____AM to_____PM Thurs. _____AM to_____PM Fri. _____AM to_____PM

Note: Please Notify the Utah VFC Program if this schedule changes (vacation, closure, etc.)

PART I: Provider Agreement

To participate in the Utah Vaccines for Children (VFC) Program and receive public funded vaccine provided to my facility at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this medical office, group practice, managed care organization, community/migrant/rural clinic, health department, or other health delivery facility of which I am the physician-in-chief, health officer, or equivalent:

1. I will screen patients and administer public funded vaccine only to a child (0 through18 years of age) who qualifies under one or more of the following categories: a) Is an American Indian or Alaskan Native; b) Is enrolled in Medicaid (or qualified through a State Medicaid waiver); c) Has no health insurance; d) Has health insurance that does not include vaccine coverage as a benefit or caps vaccine cost (under-insured); or e) Is enrolled in the Children Health Insurance Program (CHIP).

2. I will administer public funded vaccines only to children in eligible age cohorts for each vaccine, as established by the Advisory Committee on Immunization Practices (ACIP). (The ACIP Schedule is compatible with the AAP recommendations.)

3. I will comply with the appropriate immunization schedule, dosage, and contraindications, that are established by the ACIP, unless a) in my medical judgement, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate; or b) the parent/guardian claims an exemption to immunizations in accordance with the *Immunization Rule for Students* (R396-100).

Provider Agreement (continued)

4. I will maintain parent/guardian responses on the Patient Eligibility Screening Record form for a period of seven years. Release of such records will be bound by the privacy protection of the federal Medicaid law.

5. I will make records available to the Utah Department of Health (UDOH) and/or the Department of Health and Human Services (DHHS) staff during routine site visits and upon request.

6. I will distribute written Vaccine Information Statements (VIS) and maintain records in accordance with the National Childhood Vaccine Injury Act.

7. I will not impose a charge for the cost of the vaccine.

8. I will not impose a charge for the administration of the vaccine that is higher than the maximum fee established by the Center for Medicare and Medicaid Services (CMS).

9. I will not deny administration of a public funded vaccine to a child because the child's parent/guardian of record is unable to pay the administration fee.

10. I will comply with Utah VFC Program requirements for ordering vaccine, and submitting inventories and temperature logs as requested.

11. I will comply with Utah VFC Program requirements for the submission of the Quarterly Doses Administered Report and certify under penalty of law that the information contained in the reports is true.

12. I will appropriately store and handle vaccines according to the Centers for Disease Control and Prevention (CDC), the Utah VFC Program and vaccine manufacturer guidelines.

13. I will develop a written policy on the routine storage, handling, and transport of vaccines and review with staff annually.

14. I will develop a written policy on the emergency handling of vaccine (a plan of action should a storage problem occur).

15. I will notify the Utah VFC Program of any vaccine loss and I agree to reimburse for any vaccine loss in excess of $1,000.00 due to inappropriate vaccine storage and handling, if requested.

16. I will be responsible for returning all public funded vaccines to the Utah VFC Program in accordance with policy and instructions.

17. I will notify the Utah VFC Program if my practice closes or no longer serves VFC eligible clients, submit a final Quarterly Doses Administered Report and transfer any remaining VFC vaccines to another VFC Provider.

18. The Utah VFC Program may terminate this agreement at any time for failure to comply with these requirements or I may terminate this agreement at any time for personal reasons.

Signature of physician-in-chief, health officer, or equivalent | Print Name | Date

PART II: Provider Profile

A. For the 2007 calendar year, project the number of **ALL children** (VFC eligible and non-VFC) who will receive vaccinations at your health facility, by age group.

Numbers of **ALL children** who will receive vaccine in your clinic in the coming year:	<1 Year Old	1-6 Years	7-18 Years	Total

Provider Profile (continued)

B. Of the total number of children entered above (section A), how many are expected to be eligible for publicly funded vaccine, by age group and category?

	<1 Year	1-6 Years	7-18 Years	Total
VFC - Enrolled in Medicaid				
VFC - No health insurance				
VFC - Am. Indian/Alaskan Nat.				
Under-insured				
CHIP				
Total				

Type of data used to determine projections:

A. Benchmarking Data
B. Medicaid Claims Data
C. Provider Encounter Data
D. Registry Data (USIIS)
E. Doses Administered Data
F. Other_____
(Specify)

PART III: Provider Information

Please PRINT clearly or TYPE the names and medical license numbers of ALL health providers (including signing physician) who may administer vaccine. It is not necessary to include the names of staff who may administer vaccine, but rather, only those who possess a medical license or are authorized to write prescriptions.

Last Name, First, MI	Title (MD, DO, ND, NP, PA) (Provider must have prescription writing privileges)	Medicaid Provider No. / Medical License No.	Specialty Peds, Family Med, GP, Other (specify)

Provider Information (continued)

Last Name, First, MI	Title (MD, DO, ND, NP, PA) (Provider must have prescription writing privileges)	Medicaid Provider No. / Medical License No.	Specialty Peds, Family Med, GP, Other (specify)
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Last Name, First, MI	Title (MD, DO, ND, NP, PA) (Provider must have prescription writing privileges)	Medicaid Provider No. / Medical License No.	Specialty Peds, Family Med, GP, Other (specify)

This record is to be submitted to and kept on file with the Utah Department of Health Immunization Program, and must be updated yearly. The original form must be mailed, no faxed copies will be accepted.

Please Mail Form to:

Utah Department of Health
Immunization Program
PO Box 142001
Salt Lake City, UT 84114-2001
Phone: (801) 538-9450

VFC PROGRAM USE ONLY

Date Received: ____________________

Class Code: ❑ Private ❑ Health Dept. ❑ Other Public ❑ FQHC/RHC ❑ Hospital ❑ Special Project

Approved By: ____
(Signature)

Date Approved: ____________________

VACMAN Entry Date: ______________________

VACMAN Entry By: ____
(Signature)

Form 1 01/07